EXHIBIT A

medlytix

January 27, 2022

STATE FARM (R) AFFILIATE
CIOS - 00
ONE STATE FARM PLAZA
BLOOMINGTON, IL 61710

***** CONFIDENTIAL THIRD PARTY MEDICAL BILL AND NOTICE OF UNPAID MEDICAL DEBT *****

Insured Patient:	Johneisha Shelton
Insurance Claim Number:	[redacted]942Z
Insurance Policy Number:	[redacted]646V
Date of Loss:	12/18/2021
Amount Due:	$1,177.00
Service Provider Group:	Emergency Coverage Corp
Patient Account Number:	[redacted]2/401

To the insurance claims adjustor or specialist:

Medlytix is submitting medical bills on behalf of Emergency Coverage Corp, for treatment rendered to the above patient. According to our records, the patient's medical treatment costs are covered under automobile insurance policy #[redacted]646V, issued by your company. Enclosed is a treatment register of diagnosis and procedure codes rendered by the provider to the insured, Johneisha Shelton, due to injuries received from a covered motor vehicle accident. If Medical Records are required, please return our preprinted form. You may use your preferred carrier standard form of communication with Medlytix to make the request.

Please send your payment and the attached remittance page to:

EMERGENCY COVERAGE CORP
PO BOX 740011,
ATLANTA, GA 30374-0011

☐Include Insured Patient's name and the Patient Account Number: [redacted]2/401 on the check. If you have already submitted payment, please forward a copy of your payment register to Medlytix. If an attorney is representing this case for settlement, please notify Medlytix with their contact information.

How to Contact Us: If you have questions or need further assistance regarding this bill or related information, you may contact us via the following channels. **Please send patient specific information only through secure encrypted email, mail or fax.**

Medlytix Patient Account Service
675 Mansell Road, Suite 205
Roswell, GA 30076-8867

678-507-0333	Voice for Medlytix PFS Billing Inquires
PFS@Medlytix.com	Email Correspondence
678-278-2578	Fax Correspondence

Confidential Protected Patient Information for Named Carrier's Claims Processor Only. If you are not the intended recipient of this information please return to Medlytix PFS by contacting us at *678-507-0327*.

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January 27, 2022

□□□MAKE CHECKS PAYABLE TO: □□□□
EMERGENCY COVERAGE CORP
PO BOX 740011,
ATLANTA, GA 30374-0011

BILL TO:
STATE FARM (R) AFFILIATE
CIOS - 00
ONE STATE FARM PLAZA
BLOOMINGTON, IL 61710

Insured Patient	Johneisha Shelton
Claim Number	[redacted]942Z
Policy Number	[redacted]646V
Account Number	[redacted]2/401
Date of Loss	12/18/2021
Date of Service	12/18/2021

Charges	$1,177.00
Paid	$0.00
Amount Due	$1,177.00

Diagnosis Code(s):

ICD Code	Description
[redacted]	

Procedure(s) and Charge(s):

No.	Svc. Date	HCPCS	Description	Unit	Charge
1	12/18/2021	99284	EMERGENCY DEPT VISIT	1	1,177.00
				Total	$1,177.00

For immediate settlement arrangements of this bill-debt, please contact us by email at PFS@Medlytix.com. Please include the patient account number in your email to Medlytix.

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January 27, 2022

Insurance Carrier/Patient/Attorney Remittance, to ensure accurate posting of your payment, please include this document with your payment/checks.

On behalf of EMERGENCY COVERAGE CORP, Medlytix has billed the following carrier and the remittance should be posted to this carrier:

STATE FARM (R) AFFILIATE

REMITTANCE

EMERGENCY COVERAGE CORP
PO BOX 740011,
ATLANTA, GA 30374-0011

PATIENT NAME:	JOHNEISHA SHELTON
SERVICE DATE:	12/18/2021
PATIENT ACCT:	[redacted]2/401
CLAIM NUMBER:	[redacted]942Z
AMOUNT DUE:	$1,177.00
CHECK NUMBER:	
AMOUNT ENCLOSED:	

☐If paying by electronic means or credit card, please include MEDLYTIX HOLD ACCOUNT and STATE FARM (R) AFFILIATE.

Thank You

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Information Request Form from Medlytix and/or Provider

This optional form may be used to correspond with Medlytix. Information requests may include: Medical Records, questions or clarifications for the provider, and/or information correction. If you believe the information provided is incorrect or incomplete, please let us know.

The following request to Medlytix pertains to:

Insured Patient:	Johneisha Shelton
Insurance Claim Number:	[redacted]942Z
Insurance Policy Number:	[redacted]646V
Service Provider Group:	Emergency Coverage Corp
Patient Account Number:	[redacted]2/401

Request	Details
Medical Records	☐ Yes ☐ No Please check *Yes* if you require Medical Records in order to process this bill, and provide us with a secure fax number to send the medical records. If this is a third party request for Medical Records, a **signed Medical Authorization** document from the patient will be required in order to send Medical Records.
SSN, DOB, etc.	If the information provided is believed to be incomplete, please provide the following related information (For example, Patient DOB or SSN):
Feedback or **Status Update**	If you believe any of the information provided in this bill is incorrect, please specify your change request or related information here (For example, Patient was not our insured at the time of accident):

This form contains protected patient confidential information. This form should only be transmitted in a secure manner to Medlytix at the contact information provided below. Please ensure that your communications meet or exceed your company policy and all applicable State and Federal regulations regarding privacy and security of protected patient information. Information may be sent by secure email, secure Fax or Mail to any of the following:

Medlytix Patient Account Service
675 Mansell Road, Suite 205
Roswell, GA 30076-8867
678-507-0333 Voice for Medlytix PFS Billing Inquires
PFS@Medlytix.com Email Correspondence
678-278-2578 Fax Correspondence

STATE FARM (R) AFFILIATE
Claim #: [redacted]942Z
Policy #: [redacted]646V

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Confidential Protected Patient Information for Name Carrier's Claims Processor Only. If you are not the intended recipient of this information, please return to Medlytix PFS by contacting us at 678-507-0327.

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID/DoD-Ctr#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER X (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1): [redacted]942Z
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SHELTON, JOHNEISHA	3. PATIENT'S BIRTH DATE: [redacted] SEX: M F X
5. PATIENT'S ADDRESS (No., Street): [redacted]	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other X
CITY: RICHMOND STATE: VA	8. RESERVED FOR NUCC USE
ZIP CODE: 23225 TELEPHONE (Include Area Code): (804) [redacted]	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES X NO PLACE (State): VA
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO X
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
11. INSURED'S POLICY GROUP OR FECA NUMBER: [redacted]646V	
a. INSURED'S DATE OF BIRTH MM DD YY: SEX M F	
b. OTHER CLAIM ID (Designated by NUCC): Y4 [redacted]942Z	
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: SIGNATURE ON FILE DATE: 12/18/21

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 12 18 21 QUAL. 431	15. OTHER DATE QUAL. 439 MM DD YY: 12 18 21
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM TO	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY: FROM TO	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0: A. [redacted] B. C. D. E. F. G. H. I. J. K. L.	22. RESUBMISSION CODE ORIGINAL REF. NO.
	23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 12 18 21	12 18 21	23	Y	[redacted]		[redacted]	1177 00	1		ZZ NPI	207P00000X 1720185549
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: [redacted] SSN EIN: X	26. PATIENT'S ACCOUNT NO.: [redacted]2/401	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO	28. TOTAL CHARGE: $ 1177 00	29. AMOUNT PAID: $ 0 00
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) NEVAN CHANG SIGNED: SIGNATURE ON FILE DATE: 121821	32. SERVICE FACILITY LOCATION INFORMATION: CHIPPENHAM HOSPITAL 7101 JAHNKE RD RICHMOND, VA 23225 a. 1598708513 b.	33. BILLING PROVIDER INFO & PH # ( ): EMERGENCY COVERAGE CORP PO BOX 740011, ATLANTA, GA 30374-0011 a. 1427005008 b.		

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to th requester. Do n send to the IRS.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

EMERGENCY COVERAGE CORPORATION

2 Business name/disregarded entity name, if different from above

Print or type. See Specific Instructions on page 3.

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☑ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only certain entities, not individuals; s instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.

5 Address (number, street, and apt. or suite no.) See instructions.

PO BOX 740011

Requester's name and address (optional)

6 City, state, and ZIP code

ATLANTA, GA 30374-0011

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

[redacted]

or

Employer identification number

[redacted]

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I a no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding beca you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person ▶ [redacted] Date ▶ 1-2020

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

If you do not return Form W-9 to the requester with a TIN, you migh be subject to backup withholding. See What is backup withholding, *later.*